

Dakota County Board of Commissioners

Child Neglect Study

ADOPTED SEPTEMBER 22, 1998

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Executive Summary

Nearly half of the families in a recent Dakota County study of child neglect cases had histories of neglecting or abusing their children, so the researchers decided to investigate what could be done to improve the long-term results for children.

The Dakota County Human Services Advisory Committee (HSAC), a 21-member citizen group appointed by the Dakota County Board of Commissioners, studied Dakota County's response to child neglect as part of its 1997–1998 work plan. The committee reviewed 186 cases of child neglect during a six-month period, and found that nearly half had previous maltreatment cases in Dakota County, and many had multiple cases opened.

HSAC set out to learn how to reduce these instances of recurring neglect, where families are the subject of multiple case openings and closings. Committee members reviewed literature and talked to staff and other experts. They found important research results regarding the circumstances in which neglect occurs, the impairment of brain development in the first three years of life, and the impact of neglect on later learning, mental health, and behavioral problems of children.

On a typical day, Dakota County Social Services receives 55 reports of possible maltreatment from teachers, health care professionals, law enforcement personnel, neighbors and/or family members. Five of the calls meet the screening criteria for child maltreatment assessments, two of these assessments result in a finding of maltreatment, and one case is opened for on-going child protection services. Child maltreatment includes physical abuse, emotional and physical neglect, and sexual abuse.

HSAC members learned that child neglect cases make up the largest and growing proportion of child maltreatment cases in Dakota County. To better understand and respond to the issue of recurring neglect, HSAC members studied 39 families who had four to 19 prior opened cases each for child maltreatment, including child neglect, physical and sexual abuse, chemical abuse, and parent and child conflict.

The HSAC findings reflect a combination of ecological and behavioral factors related to child neglect. All of the 39 families studied were receiving financial and or medical assistance through the Employment and Economic Assistance Department and two-thirds of the families had drug abuse problems, over half had histories of domestic violence, and nearly half had mental health issues.

Committee members found two early intervention programs for high-risk families in other locales that have shown a combined county, state, and federal governmental savings-to-program cost ratio ranging from 2:1 to 3:1. Cost savings were realized in four categories:

1. Reductions in criminal justice system costs accounted for 40 percent of savings;
2. Greater tax revenues as a result of greater employment and income accounted for 26 percent of savings;
3. Less use of special education services accounted for 25 percent of savings; and,
4. Less use of welfare programs accounted for nine percent of savings.

The study notes that program costs occur at the time of intervention, while savings to government stretch out into the future. Savings reported are ones that were counted to date and don't include savings likely to be realized in future years.

Essential ingredients of successful early intervention programs -- HSAC members learned that six ingredients are essential for effective *early* child maltreatment interventions. Child maltreatment interventions should:

- ♦ *Be targeted* to the families with the highest risk.
- ♦ *Start early*, preferably during the prenatal period or shortly after birth.
- ♦ *Be sustained* at least through the child's second birthday.
- ♦ *Be frequent and home-based*.
- ♦ *Be purposeful, practical, and therapeutic*.
- ♦ *Have ties to neighborhoods and communities*.

HSAC members learned that families who will repeatedly neglect their children can be identified and that if interventions are targeted to these families, recurring incidents of child neglect are significantly reduced.

The Children's Research Center (CRC), a division of the National Council on Crime and Delinquency (NCCD), developed and implemented in several states a Structured Decision-Making (SDM) Model for helping families who have abused and neglected their children. Evaluation results where this model has been used show that:

- ♦ The risk assessment process is an effective classification tool that can be used to help set agencies' priorities, and
- ♦ Providing intensive services to high- and very-high-risk families significantly reduced the rate of subsequent re-referral. In fact these families had a lower re-referral rate than low-risk families.

Recommendations

The HSAC recommends that the County Board of Commissioners adopt the following value statement to guide the deployment of resources for child maltreatment services:

Protecting children's safety and promoting their secure attachment and healthy development is of highest priority.

The HSAC recommends that the County Board of Commissioners commit Dakota County by the year 2000 to --

- ♦ **Identify and respond to all at-risk births to prevent occurrences of child maltreatment and promote children's secure attachment and healthy development; and**
- ♦ **Identify and intensively intervene with families who have abused or neglected their children and are at high risk of repeated maltreatment in order to prevent future occurrences and to minimize the detrimental effects of child maltreatment.**

The HSAC recommends that the County Board of Commissioners direct staff to work with community leaders and the legislature to obtain additional resources to achieve these child maltreatment recommendations.

Goal One: Children are safe, secure and healthy.

- ♦ Screen all births and pregnancies for maltreatment risk factors. *Estimated-one year cost: \$110,000, or \$22 per birth.*
- ♦ Provide home visiting services from birth to age six for families with maltreatment risk factors. *Estimated one-year cost: \$2,003,750, or \$3340 per family per year.*
- ♦ Target resistive families with multiple risk factors for continued outreach and engagement. *Estimated one-year cost for training and staff coordination: \$10,000.*
- ♦ **Seek policies and legislation that more closely integrate domestic abuse and child maltreatment responses and practices. County staff works with stakeholders to address the significant overlap between child maltreatment and domestic abuse.**

Goal Two: Families use community resources and supports, e.g. school supports, faith communities, local agencies and neighbors to reduce risk factors.

- ♦ Provide strength-based assessment and response to low-risk families. *There is no current level funding for this strategy. County staff works with stakeholders, e.g. schools, to direct LCTS funds to serve these families.*
- ♦ Provide education about and encouragement to use, and facilitate access to, community resources.
- ♦ Seek Child Maltreatment Differential Response Legislation and appropriations to build community capacity. *Estimated one-year cost: \$800,000.*

Goal Three: Families with acute and chronic conditions related to child maltreatment receive intensive, sustained professional services.

1. Use Structured Decision-Making (SDM) model to target interventions to families based upon risk scores.

☞ *Estimated start-up cost: \$90,000. If development costs are shared with a neighboring county, e.g. Ramsey, this cost is reduced by half.*

- ☞ Estimated implementation cost is not known at this time. Resources for implementing SDM will come from two main sources. These are 1. Differential Response Legislature appropriation, above, and 2. Redeployment of existing resources, and 3. New resources for meeting service intensity and duration standards.

Goal Four: Children are safe and protected from maltreatment.

- ◆ There is concurrent planning for reunification and termination of parental rights for families with children in need of substitute care. *A one-year State and Federal appropriation for initial implementation: \$320,000.*
- ◆ Monitor concurrent planning implementation to determine impact and effectiveness of time limits.
- ◆ Recruit and monitor quality of interim care, e.g. foster care, group homes and adoption placements.

Introduction

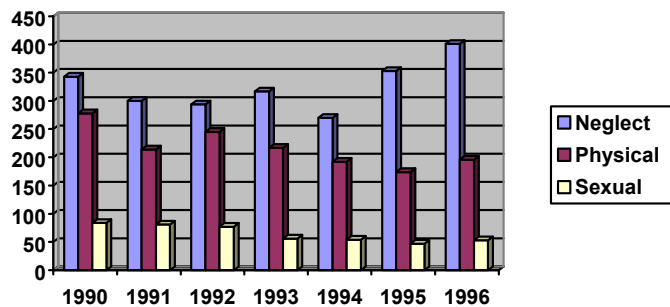
The child neglect findings and recommendations contained in this report were developed by the Dakota County Human Services Advisory Committee (HSAC). The Committee, which is a 21-member citizen group appointed by the Dakota County Board of Commissioners, elected to study Dakota County's response to child neglect as a part of its 1997 – 1998 work plan. The focus on child neglect was the result of looking at county trends in child maltreatment cases. Child maltreatment includes physical abuse, emotional and physical neglect, and sexual abuse. See Appendix A for a definition of child neglect as specified in Minnesota statute.

HSAC members learned that child neglect victims make up the largest and growing proportion of maltreated children in Dakota County. As seen in Figure 1, 61 percent of maltreatment findings were for child neglect victims in 1996 compared to 47 percent in 1990. This same trend is true for Minnesota; statewide since 1992, the most common type of maltreatment has been child neglect.

HSAC members started the study of child neglect at their August 1997 meeting. Their work took place during the next several months and addressed four questions. These are –

- **Faces of Neglect** -- What is known about child neglect in Dakota County?
- **Causes and Consequences** -- What does national research tell us about child neglect?
- **What Works** -- What changes should we consider, if any, as a result of this research?
- **Recommendations** -- What policies and strategies do we want to recommend to the County Board?

Figure 1: Dakota County Findings of Maltreatment by Type of Victim



Faces of Child Neglect in Dakota County

Parents with school children know Bobby. Their children regularly recount at the supper table his antics. He is eight years old and small for his age. His clothes are filthy, he smells of urine, he has no friends, he daily disrupts the rest of the class and his teacher is at her wit's end. His seizure disorder requires daily visits to the school nurse for medication and monitoring. He tells the nurse one morning, that his mom's boyfriend "was hitting on his mom, again last night." The neighbor knows that Bobby is regularly left home alone for extended periods of time.

Bobby's classmates give one glimpse of his life, the teacher knows the academic and behavioral challenges, the nurse knows Bobby's medical history and situation at home and the neighbor suspects he is not safe. Each one sees a fragment of the life of a neglected child. These fragments are not viewed together so the response is slow, inconsistent and inadequate.

Bobby smells like urine and his clothes are dirty – a case is opened, he is cleaned up and the case is closed. He is disruptive in class – he is referred for an ADHD (Attention Deficit Hyperactivity Disorder) assessment. County staff receive a report of domestic violence -- they interview the mom, she explains it away, they refer her to domestic abuse services at a local battered women's shelter and they close the case. Staff gets the report of inadequate supervision, they identify informal supports such as an after-school program, and they close the case.

Social Services treated these as isolated events. But in truth, these events are a child's life. Social Services plugged in isolated responses to isolated events; these did not improve Bobby's life. The problems are so much bigger. Here is what's going on in Bobby's life.

The family has been involved with Social Services on and off since Bobby's 16-year-old half-sister Katie was nine years old and Bobby was one. Social Services has opened and closed cases on Bobby's family seven times for allegations (some substantiated and some unsubstantiated) of physical abuse, educational neglect and inadequate supervision. Although Social Services has been involved with this family for seven years, Bobby's mom, Sally, has been involved with Social Services since she was a child. In effect, she has been a part of the "system" her entire life - stretching back to

when her own alcohol abusing mother and father's parental rights were terminated. Sally has a history of school and employment failure, abusing alcohol and drugs, and two failed marriages steeped in violence.

This case composite represents a typical child neglect case in HSAC's study. There were many more complex and severe cases, and several cases that were less complicated. The responses are consistent with protocol when using the measure of "imminent harm" which is the presence of a clear, immediate threat to a child's safety. Staff regularly face the dilemma of children mired in marginal care but evade the strict interpretation of "imminent harm" required for child protection intervention (Wattenberg, 1995). Hence, the underlying problems are not addressed; only the symptoms are – and not very effectively.

On a typical day, Dakota County Social Services intake social workers receive 55 calls from teachers, health care professionals, law enforcement, neighbors and/ or family members. Five of these calls meet the screening criteria for child maltreatment assessments, two of these assessments result in a finding of maltreatment and one case is opened for on-going child protection services. Figure 2 depicts the funnel effect of child protection calls, investigations/assessments, determinations and case openings based on annual data (Actual numbers of Child Protective Services calls are in Appendix B). (Dakota County Social Services Assessment and Screening Criteria is shown in Appendix F.)

One on-going child protection case is opened for every 55 calls made by professionals, citizens, and family members to Social Services. Investigation/assessment cases (5 Investigated) are closed within 90 days. Families requiring services of longer duration are referred to on-going child protection (one case opened). This funnel effect is a function of the level of neglect a community is willing to tolerate, priorities of administrators, resource allocation of elected officials, and the historical tension between the government's responsibility to protect its most vulnerable citizens and a family's right to privacy.

Dakota County Study of Child Neglect Cases

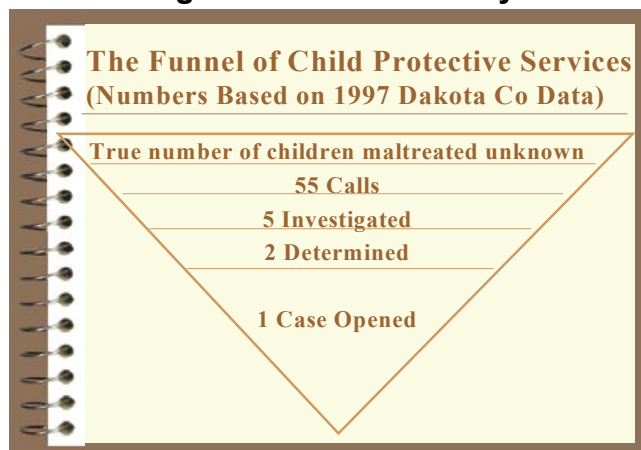
HSAC members studied a sample of 186 child neglect families served by the Social Services Department. These families were the subjects of child neglect assessments during the first six months of 1997. Their study examined assessment activity, how often child neglect was substantiated, whether services were provided, and whether families had open cases in Social Services prior to the 1997. The findings are listed here.

1. Child neglect was substantiated in over half (53 percent) of the assessments conducted. This compares to a determination rate of 40 percent (two out of five) for all types of maltreatment.
2. Less than a quarter (20 percent) of the 186 families were provided with on-going protective services; this is the Funnel Effect. (See Figure 2.)
3. Seventy-five percent of the 186 families received or were receiving services from the county departments of Public Health and Employment and Economic Assistance. Examples of services provided include financial grants, medical assistance, child support and collections, disease prevention, and health promotion.
4. **Nearly half (86 or 46%) of the 186 families had open cases in Social Services prior to the 1997 child neglect assessment. Furthermore, nearly one-half of these 86 families or 39 families had four to 19 prior opened cases in Social Services for child maltreatment including child neglect, physical and sexual abuse, chemical abuse, and parent and child conflict.** According to Esther Wattenberg, national expert on child maltreatment from the University of Minnesota, the "recurring neglect" population in national studies ranges from 20 to 30 percent of all cases investigated.

To better understand and respond to the issue of "recurring neglect" where families are the subject of multiple case openings and closings, HSAC members studied these 39 families. The findings from an in-depth case review and analysis are highlighted here and organized according to Family Member Data, Open Case History, and Qualitative Findings.

Family Member Data: These 39 families are made up of 178 family members, including 70 adults and 108 children. The average number of family members per family was 4.5, with a range of two to nine. A typical family was a mom, a male live-in companion, and two or three children. The other findings below are summarized by this question: How does a domestic abuse victim living in poverty provide competent care to two or three children with behavioral and health problems?

Figure 2: Dakota County



1. **Poverty** – One-hundred percent of the families receive(d) public assistance, including financial grants and medical care.
2. **Mobility/Homelessness** – As might be expected this is not a stable population. Twenty-six of the 39 families moved five or more times. The average number of moves per family was seven, the range one to 24. These numbers are based on address changes, and only reflect reported changes. Hence, the counts reported here are minimums. Furthermore, one-third of the families has been homeless, and nine of the families are obtaining services from the new transitional housing unit.
3. **Health** – Nearly three-fourths of the families also receive(d) services from Public Health, including Maternal and Child Health, immunizations, communicable disease control, community alternatives for disabled individuals (CADI), and personal care attendants. This percentage could be higher if WIC (Women, Infant and Children) families were included. The same pattern of multiple case openings and closings was observed in Public Health cases.
4. **Children's Ages** – The average age of children when cases were first opened was six years. This compares to 11 years of age at the last case closing, indicating an intermittent involvement of five years. A bi-modal distribution of the ages indicates that neglect is most frequently identified when children are infants and toddlers, and then as early elementary students. National studies show that young children are the most susceptible to be in a neglectful home. The highest rates of neglect occur for children who are under two years of age (Wattenberg, 1994.)
5. **Adults in Household** – Two-thirds of the families had more than one adult in the home. An evaluation of the Hawaii Healthy Start Program found that the presence of other adults (e.g. significant others, step-parents, relatives) in the household resulted in more problematic parenting, contrary to the expectation that living with other adults would be beneficial (Daro, 1998). Thirty-seven of the 39 families were also involved with the Child Support and Collections unit. Of these 37 families, 28 had paternity cases filed, which means the father was not married to the mother and most likely was not the other adult in the household.
6. **Domestic Violence** – Case record data showed that the 56 percent of the primary caregivers experienced domestic violence in their adult relationships. Eight of the 39 families or 20 percent used the services of battered women's shelters on one or more occasion.
7. **Children in Household** – Fifty-two percent of the families had three or more children. The significance of this is heightened when considering the high number of children with multiple problems and/or disabilities as indicated in the qualitative findings.
8. **Disability** – For one-third of the family members a disability was recorded. Examples of disability include diagnosis of severe emotional disturbance and physical, mental, developmental and sensory disabilities. Twice this level of disability (or two-thirds of the family members) was found in the case notes and is reported in the qualitative findings.
9. **Out-of-Home Placements** – Three-quarters of the families had children placed out of the home. A total of 60 or 53 percent of the children in the study population were placed in out-of-home care at least once. Several of these children experienced multiple out-of-home placements. Placements included stays with non-custodial parents, relatives, foster parents, and in residential treatment.
10. **Minority Populations** -- Eleven percent of the families in the study population are members of minority groups. The minority population for Dakota County is 6.4 percent -- (Asian - 2.4%, Hispanic - 2%, African American - 1.6%, and Native American -- 3%). State statistics show that children of color are more likely to have neglect cases substantiated. American Indian children are three times and African American children are twice as likely to be in the neglect category than in the physical abuse category (Wattenberg, 1994).

Note: School Districts with minority populations higher than the County rate are -- West St. Paul - 17%; Burnsville - 14%; Inver Grove Height - 11%; Rosemount, Apple Valley - 10%; South St. Paul - 9% (Source: 1996 Census; MN Dept. of Children, Families and Learning, 1997-98).

Open Case History: 314 cases were opened for the 39 families. This was an average of 8.2 case openings/closings per family over an average "case life" of five years. The first case in the study population was opened in 1982. Several cases are open now.

1. **Lots of Assessment; Little Sustained Service** -- Over one-half of the case openings were for assessment, with another one-fourth for on-going child protection services. This represents a significant amount of assessment/investigation and little sustained service. Generally, cases opened for investigation/assessment and not transferred to on-going protective services are provided short-term interventions and closed within three months.
2. **Multiple Problems** -- Although one-half of the opened cases were for the problem of child neglect, 34 of the 39 families had cases opened and closed not only for child neglect but also for other problems, including physical and sexual abuse, mental and chemical health.

3. **Purchased Services for Families** – Serving these 39 families is costly. The average expenditure for purchased services, over the life of a case was \$12,375, ranging from a high of \$99,875. (n=1) to zero (n=8). The average case life in this study is five years, which results in an averaged annual cost of \$2475. This does not include county costs associated with social worker time for conducting assessments and providing on-going services nor does it include purchased or direct service costs in Public Health and Employment and Economic Assistance. Furthermore, research shows that in the future it is quite likely that some of these children will incur significant costs in the community corrections system, in long term welfare dependency as well as in special education (Karoly, 1998).

Qualitative Findings: Thirty-nine case histories were examined in their entirety. Figure 3 shows the reasons these cases came to Social Services most recently.

Figure 3: Nature of Complaint

Complaint	Number	Percent
Inadequate supervision due to drug use	9	23
Failure to protect	5	13
Improper supervision	7	18
Witness domestic violence	4	10
Educational neglect	3	8
Improper hygiene	5	13
Other	9	23
Total	39	100

Examples of the types of complaints coded as “other” includes: unsafe living conditions, parents or siblings giving another child drugs, chronic head lice, and parental mental illness.

Figure 4 shows the problems underlying the complaints delineated above. Of significance are 1) chemical abuse; 2) domestic abuse; 3) mental health issues; 4) children with multiple presenting issues; and, 5) parental childhood histories of physical and sexual abuse.

Figure 4: Family Problems

Problems	Number	Percent
Adult caregiver chemical abuse issues	23	59
Violence in caregivers’ adult relationships	22	56
Abuse in caregivers’ families of origin	20	51
Adult caregiver mental health issues	18	46
Children with mental health issues	16	41
Children who have been sexually abused	15	38
Children who have multiple problems	15	38
Children with medical issues/conditions	10	26
Children with borderline intelligence or learning disabilities	8	20
Children who have been sexual perpetrators	5	13

Note: The frequencies in Figure 4 are based on files that specifically mention these issues. Failure to record the issues does not necessarily indicate their absence. For example, social workers are not guided by protocol to collect information on the parent’s childhood history of abuse or neglect or other factors that are predictive of future child maltreatment.

Nearly 60 percent of the families had chemical abuse issues, 56 percent had domestic violence issues, 51 percent had histories of abuse in families of origin and 38 percent had children with multiple problems.

The multiple case openings and closings, coupled with the persistence of underlying family problems, demonstrated to HSAC that Dakota County Social Services is not getting adequate outcomes for children who have been neglected. This finding convinced HSAC members of the need to determine not only how children who are chronically neglected can be protected, but also to learn more about the causes and consequences of child neglect and about ways to intervene early to prevent child neglect.

Causes of Child Neglect

HSAC members reviewed key national studies on the causes and consequences of child neglect. In addition, they heard from county social workers, law enforcement personnel, school nurses and University of Minnesota child welfare researchers.

The antecedents of child neglect were evident in Bobby's life – family violence, substance abuse and poverty. During nine months of prenatal development and the first two years of his life, environmental toxins, in the form of prenatal alcohol and substance abuse, and his parent's interpersonal violence and poverty of purse and spirit bombarded Bobby.

The major setting for violence in America is the home (Strauss, 1974, as referenced in Perry, 1995). Interfamilial abuse, child neglect, and domestic battery account for the majority of physical and emotional violence suffered by children in this country (Perry, 1995).

Several national studies provide insight into the reasons for the steady growth in child neglect cases. The most comprehensive national study of child maltreatment compared families with an annual income of under \$15,000 with families with an annual income over \$30,000. The survey found abuse to be 14 times more common, and **child neglect to be 44 times more common, in poor families (Schorr, 1998)**. Another study found that the strongest predictors of maltreatment in a community are the percentage of families with incomes less than 200 percent of poverty and the percent of vacant housing (Zuravin, 1992 as referenced in Wattenberg, 1995). These researchers argue forcibly for a broader "ecological" definition of neglect, stressing that child neglect is as much a function of a community's health and resources as a family's.

Diana English's national child neglect research found that the most important child neglect risk factors are related to the seemingly intractable parental behavioral problems of family violence and substance abuse, as well as environmental conditions related to poverty. National research also tells us that a high percentage of neglecting caretakers suffer from clinical depression and have childhood histories of abuse and neglect (Wattenberg, 1995).

Dakota County social workers, housing support specialists, and public health nurses see the same causes. They say that neglecting families often live chaotic lives. They see poverty contributing unmanageable stresses to families characterized by school failure, violent and dysfunctional relationships, isolation and depression.

The child and the adult reflect the world they are raised in. And, sadly, in today's world, millions of children are raised in unstable and violent settings. Literally, incubated in terror (Perry, 1995).

The findings from the HSAC study of child neglect reflect this combination of ecological and behavioral factors. **One-hundred percent of the 39 families were receiving financial and or medical assistance through the Employment and Economic Assistance Department and two-thirds of the families had drug abuse problems, over half had histories of domestic violence, and nearly half had mental health issues.**

Consequences of Child Neglect

The consequences of child neglect are vividly portrayed in Bobby's life. At the young age of eight, he has four irreversible rotten outcomes including a chronic health condition, a small stature, behavior problems (no friends) and a diagnosis of ADHD. These outcomes are not random occurrences; they are predictable and are the result of prenatal drug and alcohol use, domestic violence and child neglect (Perry, 1995). His course is set. Research shows that he has a strong possibility of ending up in special education, eventually dropping out of school, and finally being involved in criminal activity (Wagner, et al., 1992 as referenced in Evelo, et al., 1996).

In the last decade, technological advances have allowed scientists to study the brains of living people, including those of infants and toddlers. Using new tools (ultrasound, MRI, PET, and EEG,) scientists can study the function, structure, and energy of the active human brain. What they have learned has changed the way we view the human capacity of learning and emotional growth. Brain development research provides several key findings that have a direct impact on how we interact with young children and how we respond to child maltreatment. They are specific and easy to understand.

1. Brain development is contingent upon a complex interplay between genes and the environment. Heredity lays down a complex system of brain circuitry (cells), and external forces (nutrition, surroundings, and stimulation) determines how the circuitry is “wired.”
2. Early experiences contribute significantly to the structure of the brain and its capacities. The quality, quantity, and consistency of care and stimulation provided to infants determine, to a large extent, the number of brain synapses (connections between cells) that are formed and how they function. This is true for both cognitive and emotional development. Researchers at Baylor University found that children who don’t play much or are rarely touched develop brains 20 to 30 percent smaller than normal for their age (Nash, 1997). The effect is lifelong and not readily altered. The most critical period for making these connections is the first 36 months of life.
3. Early interactions – the quality of how we relate and respond – directly affect the way the brain is wired. Brain cell “connections” are established as the growing infant experiences the surrounding world and forms attachments to others. Warm, responsive care appears to have a protective biological function, helping the child to weather ordinary frustrations and prepare for the adverse effects of life’s later stresses and challenges. On the other hand, infants who endure trauma, non-responsive or inept care suffer cognitive and emotional developmental disturbances that adversely affect their ability as children and adolescents to learn and manage emotions. (Schiller, 1997).
4. The brain develops in sequence with more primitive structures (brainstem and midbrain) stabilizing connections first and high order structures (cortex) developing last. According to Dr. Bruce Perry, a Baylor University neurologist, this has great significance for abused and neglected children. He reports, “children who are maltreated early in life develop brains that are exquisitely tuned to danger. At the slightest threat, their hearts race, their stress hormones surge and their brains anxiously track the nonverbal cues that might signal the next attack” (Nash, 1997). As babies and toddlers, these children spend so much time in fear (governed by the brainstem and midbrain areas), those higher order brain functions (language, reasoning) of the cortex don’t develop normally. Perry reports on clinical observations of teachers. “These children are really smart but can’t learn easily. Often these children are labeled as learning disabled. These difficulties with cognitive organization (thinking and reasoning) contribute to a more primitive, less mature style of problem-solving with violence being employed as a tool” (Perry, 1995).

Through the interplay of the developing brain with the environment during the nine months of gestation and the first two years after birth, the core of an individual’s ability to think, feel, and relate to others is formed. (Karr-Morse, 1997).

Martha Erickson and Byron Egeland, nationally recognized child maltreatment researchers from the University of Minnesota have completed a 19-year longitudinal study of 267 high-risk mother-infant pairs. Their findings leave no doubt that child neglect has pervasive and severe developmental consequences. In fact, of all the maltreated children in the study (including physical abuse), the neglected children had the most difficult time in school. By the time these children were in early elementary school, they had deficits in cognitive performance, academic achievement, behavior in the classroom, and social interactions. By second grade, all of the neglected children were in special education programs (Egeland, 1991 as referenced in Kendall-Tackett, 1996).

Although national studies on causation of juvenile violence are not easily found, directors of juvenile facilities report that an overwhelming majority of their detainees have diagnosis of ADHD. Robin Karr-Morse reports in her new book, *Ghosts from the Nursery*, “While ADHD predominately affects attention, it may compromise learning and typically has some negative impact on a child’s judgment. It is the element of hyperactivity, however, that is more commonly the root factor in aggressive or violent behavior, due to the added behavioral elements of impulsivity and restlessness.” In other words, youth violence is the product of an inability to think (the process of employing reason and empathy) before acting.

School failure is highly correlated with learning and behavioral problems. Thirty-seven percent of all youth with disabilities drop out of high school and 59 percent of students with an emotional/behavioral disability drop out of high school. Of all youth with emotional/behavioral disabilities who have dropped out of school, 73 percent have been incarcerated within three to five years after leaving school (Wagner, et al., 1992 as referenced in Evelo, et al., 1996). See Appendix C for a summary of the consequences of child neglect and domestic violence.

What Works?

HSAC members reviewed national literature and heard from County experts and a University of Minnesota researcher on effective child neglect interventions. Members learned that when looking at what works in preventing and responding to child neglect, it is helpful to think about general and targeted services.

Good housing, adequate financial support, available and affordable childcare and health care, early intervention services for children with disabilities, school-based supports, and neighborhood centers are examples of general services. These services

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build on the “ecological” aspect of child neglect. They make up an essential framework of support to parents so parents can provide good care to their children. For example, availability of good childcare can break a cycle of neglect; parents can work outside the home and feel better about themselves and their children. In contrast, inadequate childcare means that a single parent is unlikely to look for a job or return to school and must care for the children every day without a break. For children whose parents are steeped in violence and drugs and who live chaotic lives, good childcare is often the only stable force in their lives.

In addition to these general services, HSAC members reviewed research that supports the importance of targeted early interventions in the form of home visiting to prevent child neglect. Perhaps the most comprehensive review of what works in child maltreatment is the 1998 RAND report, *Investing in Our Children, What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions*. This report presents the findings on 11 early childhood intervention programs, including Perry Preschool, Elmira Home Visiting (Olds, 1997) and Carolina Abecedarian (Ramey, 1992). Significant reductions in the rates of abuse and neglect are found in the intervention groups versus the comparison groups (Karoly, 1998). Other documented advantages for early intervention program participants compared to the control groups include:

- ◆ Gains in emotional or cognitive development for the child, typically in the short run, or improved parent-child relationships;
- ◆ Improvements in educational process and outcomes for the child;
- ◆ Increased economic self-sufficiency, initially for the parent and later for the child, through greater labor force participation, higher income and lower welfare usage;
- ◆ Reduced levels of criminal activity; and,
- ◆ Improvements in health-related indicators, such as child abuse, maternal reproductive health, and maternal substance abuse.

Figure 5 shows the cost savings for the treatment populations in two early intervention programs – Elmira Home Visiting and Perry Preschool. For high-risk families, the county, state and federal governmental saving to program cost ratio ranged from 2:1 to 3:1. Cost savings were realized in four categories:

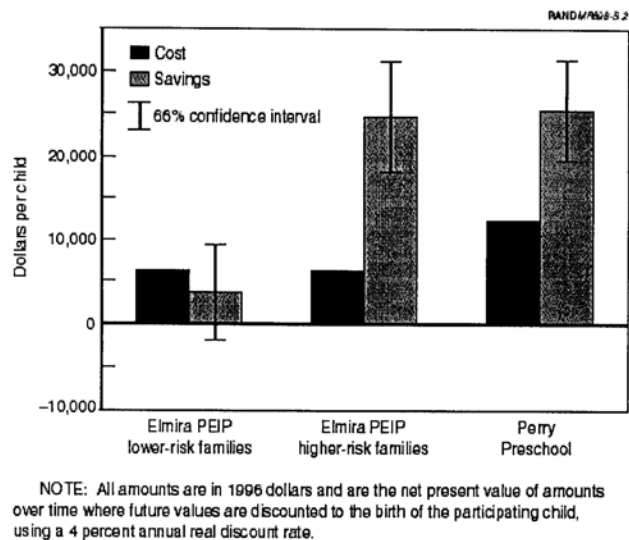
- ◆ Reductions in criminal justice system costs accounted for 40 percent of savings;
- ◆ Greater tax revenues as a result of greater employment and income accounted for 26 percent of savings;
- ◆ Less use of special education services accounted for 25 percent of savings; and,
- ◆ Less use of welfare programs accounted for nine percent of savings (Karoly, 1998).

It is important to note that program costs occur at the time of intervention, while savings to government stretch out into the future. Savings reported here are ones that were counted to date and don't include savings likely realized in future years.

Essential ingredients of successful early intervention programs -- HSAC members learned that there are six essential ingredients for effective early child maltreatment interventions. Child maltreatment interventions should:

1. **Be Targeted** – This requires that families are assessed and classified into different risk categories based on observed rates of subsequent maltreatment. For early intervention services, all families are screened and for intervention services, at-risk families are screened. Intensive interventions are then targeted to the families with the highest risk (Baird, 1998). The RAND study also found that in the case of providing services to lower-risk families, the savings to government are unlikely to exceed the costs, see Figure 5 above. This finding illustrates the importance of targeting programs to high-risk populations if government savings are to exceed costs (Karoly et al., 1998).
2. **Start Early** – Services should begin early, preferably during the prenatal period or shortly after birth. This is supported by attachment theory (Egeland & Erickson, 1989) and brain development research (Perry, 1995).

Figure 5: Program Costs Versus Savings



3. **Be Sustained** – The research suggests that service duration needs to be at least through the child's second birthday. Although reductions in child maltreatment were achieved during the first 24 months of service in the Elmira project, reductions were not sustained when the children were reevaluated at 25 to 50 months of age. Yale University pediatrician and researcher John Leventhal suggests, "Like many human services interventions for high-risk families, home visiting should NOT be viewed as an inoculation that provides life-time protection, but rather as a service that may need to be continued (with varying degrees of intensity) for many years of the child's life." (Leventhal, 1996) This is consistent with Wattenberg's finding that children age two and under have the highest rates of child neglect.
4. **Be Frequent and Home-Based** – To establish relationships, services need to occur frequently enough to build trust with the family. Frequent contact also enables the home visitor to recognize problems early and to provide the necessary services. Weekly visits the first two years with fewer visits according to the family's need in subsequent years is suggested in both the Olds' study (Elmira) and Hawaii Healthy Start.
5. **Be Purposeful** – Interventions are based upon established protocols and are practical and therapeutic. The home visitor models effective parenting and suggests alternative ways to handle situations. Goals and approaches are tailored to the needs of families, and issues of domestic violence, mental illness, parental childhood history of abuse, and chemical use are addressed if they are present. This approach requires regular assessment of the family's progress and strategic use of other services. Home visitors need to be trained to work with vulnerable families and need supervision with expertise in issues of health, mental health and child development (Leventhal, 1996).
6. **Have ties to neighborhoods and communities** – Home visitors deal with children in the context of their families and they deal with families as parts of communities. They seek ways to address issues of isolation, to promote connections to neighborhoods and communities, and to develop competencies in their families as parents, students, neighbors and employees.

Martha Erickson, in a video-taped presentation to the HSAC, noted that in her 19-year longitudinal study, 70 percent of the high-risk parents who had childhood histories of abuse either abused and neglected their children or provided marginal care. This lead Erickson to study the other 30 percent who as children were abused but as adults did not neglect or abuse their children. She found three essential factors. These parents:

1. Had a supportive adult available to them during childhood;
2. Had a supportive partner when they became parents; and,
3. Had some resolution in regard to their own childhood experience (usually through therapy of at least six months duration).

HSAC members learned that these factors should be understood by professionals, be they home visitors, social workers or public health nurses, and should be reflected in practice protocol. Consideration should be given to how mentors are used for young children, how domestic partner relationships are addressed, and how mental health services are used.

Essential ingredients of successful intervention programs – HSAC members were interested not only in successful early interventions, but also in interventions for families who have maltreated their children. This includes responses for families with significant and recurring problems. HSAC members learned that families who will repeatedly neglect their children can be identified and that if interventions are targeted to these families, recurring incidents of child neglect are significantly reduced.

The Children's Research Center (CRC), a division of the National Council on Crime and Delinquency (NCCD), developed and implemented in several states a Structured Decision-Making (SDM) Model for helping families who have abused and neglected their children. The model has five basic components:

1. Highly structured assessments of family risks and needs based upon predictive factors;
2. Service level standards that clearly define different levels of case contact, based on risk levels;
3. A workload accounting and budgeting system that translates service standards into resource requirements and helps deploy resources equitably throughout the organization;
4. A system of case review and reassessment to expeditiously move cases through the system; and,
5. A comprehensive information system to provide data for monitoring, planning and evaluation.

Four Wisconsin counties have used this system for two years. Evaluation results show that –

- ◆ The risk assessment process is an effective classification tool that can be used to help set agencies' priorities, and
- ◆ Providing intensive services to high- and very-high-risk families significantly reduced the rate of subsequent re-referral. In fact these families had a lower re-referral rate than low-risk families.

These results affirm the findings of an earlier evaluation of SDM conducted in Michigan.

What Works – What’s Next? These successful interventions – both for high-risk families and for where maltreatment exists -- suggest a need for a continuum of responses to at-risk children and families for Dakota County. Read Figure 6 - **The Continuum of Responses for At-Risk Children and Families**, on the next page. The guiding value statement is – “Protecting children’s safety and promoting their secure attachment and healthy development is of highest priority.”

The continuum begins with Screening and Targeted Early Intervention to families who are at risk for child maltreatment. This includes screening all births to Dakota County residents for child maltreatment risk factors, and aggressive outreach to families who have multiple risks and are initially resistant to services. Screening and Early Intervention is not mandated by the state. Participation for families is voluntary.

Supportive Intervention is the second column on the continuum. The goal of supportive intervention is to reduce risk factors and promote use of community resources including school services, faith communities, childcare and neighbors. These are representative of informal “ecological supports.” Like Screening and Early Intervention, supportive intervention is a non-mandated, voluntary service.

The last two columns on the continuum – Mandated Intervention and Maximum Intervention are required by state statute, and are not voluntary. The Mandated Intervention is based upon the Structured Decision-Making model. This model uses an assessment tool to determine family risk scores and to prescribe the intensity and level of service needed (see Appendix D). Maximum Intervention uses the strategy of concurrent planning. This means simultaneous plans are developed and implemented to return children to their parental homes and to make out-of-home placement in some other permanent setting, e.g. adoptions, relative foster care, etc. Timeframes for achieving reunification with parents or alternative permanent placement are based upon the children’s ages and are rigorously applied.

The strategies listed on the continuum are the basis of the HSAC recommendations to the Dakota County Board of Commissioners presented in the final section of this report.

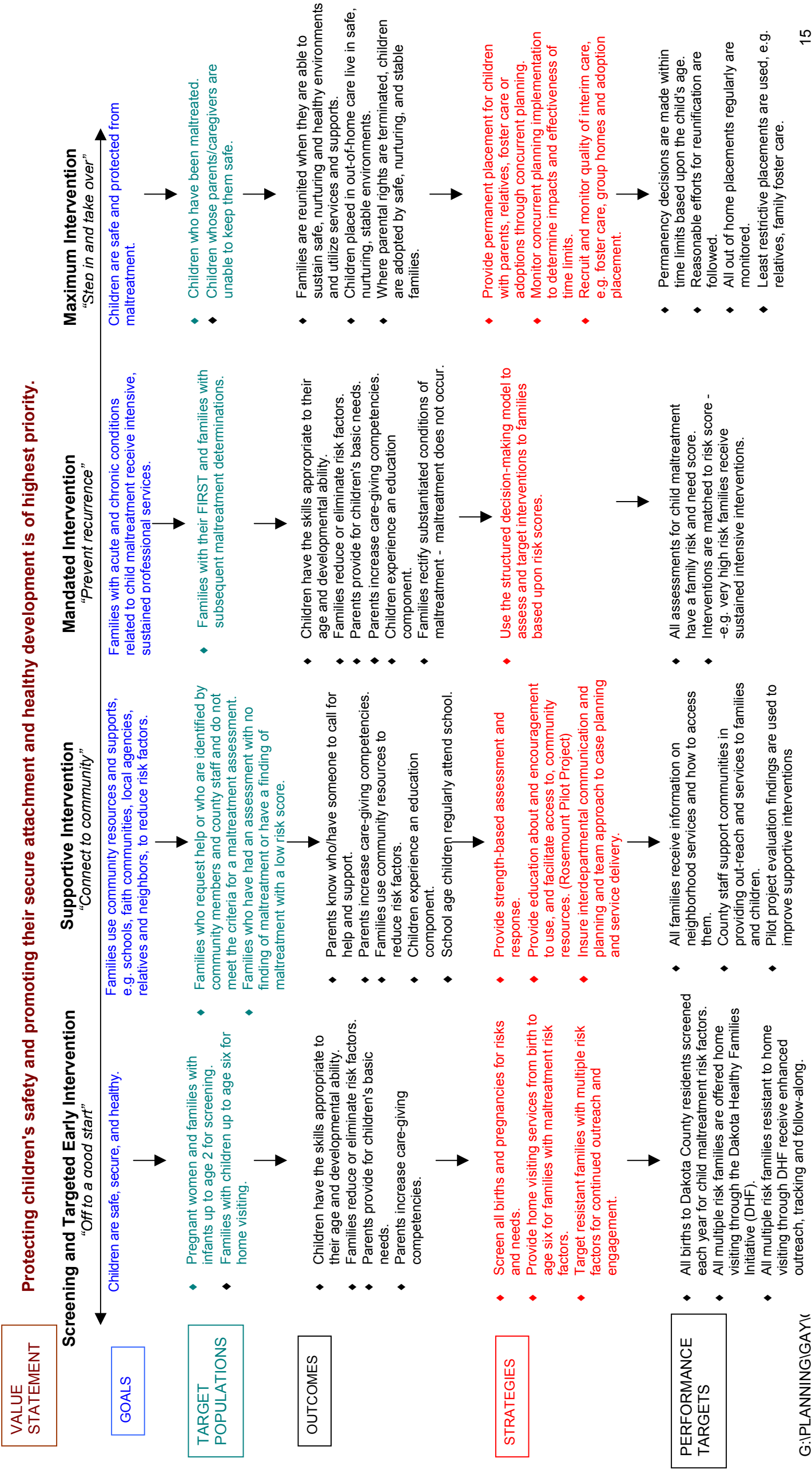
Implications

The Continuum of Responses for At-Risk Children and Families will affect current practice in several significant ways. The Funnel Effect depicted on page five will be altered. No longer will 55 calls generate five investigations, two determinations and one opened case for on-going child protective services. Instead families will be eligible for four different levels of service.

Screening and Targeted Early Intervention and Supportive Intervention – The number of families in these first two levels of service will increase significantly. By serving more families on the “front-end” and improving their parenting skills and supportive networks, reports to Social Services of child maltreatment will decrease overtime. However, it will take several years to “get ahead of the problem.” Additionally, funding for supportive intervention is extremely limited and legislative action will be needed to fully fund this strategy.

Mandated Intervention and Maximum Intervention – Because 46 percent of investigations today are for recurring families, investigations should decrease overtime, although the number of cases investigated will remain fairly constant in the short-term. Use of the Structured Decision-Making model will mean, that families identified as high- or very-high risk will receive intensive interventions. In other words, these families will no longer be subject to repeated investigations; they will receive sustained services. Whether or not maltreatment is found, cases will be opened based on families’ risk and need scores. What is anticipated is that the number of investigations will decrease and the number of cases opened will increase overtime. This is of course related to Dakota County population growth. For maximum interventions, governmental actions will be more timely regarding permanent placement of children with parents, relatives, or through adoptions. This means that for parents who are unable or unwilling to keep their children safe, their parental rights will be terminated earlier.

Continuum of Responses for At-Risk Children and Families



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Recommendations

The HSAC recommends that the County Board of Commissioners adopt the following value statement to guide the deployment of resources for child maltreatment services:

Protecting children's safety and promoting their secure attachment and healthy development is of highest priority.

The HSAC recommends that the County Board of Commissioners commits Dakota County by the year 2000 to --

- ☞ **Identify and respond to all at-risk births to prevent occurrences of child maltreatment and promote children's secure attachment and healthy development; and**
- ☞ **Identify and intensively intervene with families who have abused or neglected their children or are at high risk of repeated maltreatment in order to prevent future occurrences and to minimize the detrimental effects of child maltreatment.**

The HSAC recommends that the County Board of Commissioners directs staff to work with community groups and the legislature to obtain additional resources to achieve these child maltreatment recommendations.

The quality of the environment and the kind of experiences children have may affect brain structure and function so profoundly that they may not be correctable after age five. If we had a comparable level of knowledge with respect to a particular form of cancer or hypertension or some other illness that affected adults, you can be sure we would be in action with great vigor. (Dr. Ramey, as referenced in Karr-Morse and Wiley, 1997).

Strategies

Goal One: Children are safe, secure and healthy.

Strategies and Cost Implications:

1. Screen all births and pregnancies for maltreatment risk factors. Estimated one-year cost: \$110,000, or \$22 per birth.
2. Provide home visiting services from birth to age six for families with maltreatment risk factors. Estimated one-year cost: \$2,003,750, or \$3340 per family per year. The five-year estimated cost is \$3,673,250. See Appendix E for detailed cost estimates.
3. Target resistant families with multiple risk factors for continued outreach and engagement. Estimated one-year cost for training and staff coordination: \$10,000.
4. Seek policies and legislation that more closely integrates domestic abuse and child maltreatment policies and practices. Domestic abuse programs are under the jurisdiction of the Minnesota Department of Corrections, while child maltreatment programs are the responsibility of the Minnesota Department of Human Services. County staff works with state and local stakeholders to address the significant overlap between child maltreatment and domestic abuse.

The child welfare system forges its policy decisions not by how well children and families will be served, but by how well the decisions will serve the public coffers. If we are not willing to support the resources necessary to assure the child's well being, who are the beneficiaries of the so-called cost savings? Should neglected children bear the costs and consequences of fiscal savings? Jeanne Giovannoni

Goal Two: Families use community resources and supports, e.g. school supports, faith communities, local agencies and neighbors to reduce risk factors.

Strategies and Cost Implications:

1. Provide strength-based assessment and response to low-risk families. There is no current level funding for this strategy. County staff works with stakeholders, e.g. schools, to direct Local Collaborative Time Study (LCTS) funds to serve these families.
2. Provide education about and encouragement to use, and facilitate access to, community resources.

3. Seek Child Maltreatment Differential Response Legislation and appropriations. Estimated one-year cost: \$800,000.

Goal Three: Families with acute and chronic conditions related to child maltreatment receive intensive, sustained professional services.

Strategies and Cost Implications:

1. Use the Structured Decision-Making (SDM) model to target interventions to families based upon risk scores.

- ☞ Estimated start-up cost: \$90,000. If development costs are shared with a neighboring county, e.g. Ramsey, this cost is reduced by half.
- ☞ Estimated implementation cost is not known at this time. County staff needs one year of using the risk assessment tool to determine what percent of the Social Services' caseload is very high, high, moderate and low risk. Once this information is available, resource requirements can be calculated. Resources for implementing SDM will come from three main sources. These are 1. Differential Response Legislature appropriation above, 2. Redeployment of existing resources and 3. New resources for meeting service intensity and duration standards.

Goal Four: Children are safe and protected from maltreatment.

Strategies and Cost Implications:

1. There is concurrent planning for reunification and termination of parental rights for families with children in need of substitute care. A one-year State and Federal appropriation for initial implementation: \$320,000.
2. Monitor concurrent planning implementation to determine impact and effectiveness of time limits.
3. Recruit and monitor quality of interim care, e.g. foster care, group homes and adoption placements.

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Appendix A	Statutory Definitions of Child Neglect
Appendix B	Child Protective Services Calls Trend Data
Appendix C	Consequences of Child Neglect and Domestic Violence on Children
Appendix D	Structured Decision-Making Model (Examples of Assessment Tool and Service Level Standards)
Appendix E	Cost Projections and Options for Implementation of Screening and Targeted Early Intervention
Appendix F	Dakota County Social Services Child Maltreatment Screening Criteria

Definition of Child Neglect

Minnesota statute identifies six areas of child neglect. These include –

- Inadequate food, shelter, clothing, medical care or supervision
- Illegal placement or abandonment
- Educational, psychological and emotional neglect
- Unable or unwilling to protect
- Prenatal exposure to controlled substance
- Exposure to threatening or endangering conditions

Child Protective Service Data

	Total Calls[^]	Assignments / Investigations	Cases of abuse or neglect determined*	Child protection case is opened*
USA	N/A	1.63 million	603,000 (38%)	N/A (1994)
Minnesota				
1990	N/A	16,904	6,742 (40%)	3,298 (20%)
1992	N/A	17,988	7,131 (40%)	3,375 (19%)
1994	N/A	17,943	7,037 (39%)	3,016 (17%)
Hennepin County				
1990	N/A	4,099	1,757 (43%)	674 (16%)
1992	32,067	5,393	2,078 (38%)	734 (14%)
1994	37,887	5,812	2,077 (36%)	503 (9%)
Ramsey County				
1990	est. 22,000	1,776	838 (47%)	459 (26%)
1992	est. 22,000	1,871	972 (52%)	467 (25%)
1994	est. 22,000	1,796	991 (55%)	447 (25%)
Dakota County				
1992	8,414	1,066	387 (36%)	195 (18%)
1994	12,392	905	391 (43%)	191 (21%)
1997	12,228	1,025	429 (41%)	223 (22%)

[^] Dakota County calls equal all calls; not only child maltreatment calls.

* Expressed as a percentage of Assignments/Investigations

N/A = not available

1997 Population Estimates

United States – 267,636,061

Hennepin County – 1,053,178

Ramsey County – 484,354

Dakota County – 334,585

Sources: U.S. Department of Health and Human Services, Minnesota Department of Human Services, Hennepin and Ramsey Counties. Dakota County Social Services, Dakota County. Also, see Wattenberg, E. & Kim, H.A. Report on Child Maltreatment: the State of Minnesota 1991-1994, University of Minnesota, 1997. United States Census Bureau – 7/1/1997.

Consequences of Child Neglect and Domestic Violence

Age	Emotion	Cognition	Behavior
Infancy and Pre-school	<ul style="list-style-type: none"> ♦ Panic, anxiety ♦ Anxious attachment to parents ♦ Separation anxiety ♦ Numbing of emotions ♦ Irritability 	<ul style="list-style-type: none"> ♦ Short-term memory of events ♦ Limited understanding of violence ♦ Concerns about disruption of routines 	<ul style="list-style-type: none"> ♦ Withdrawal, passivity ♦ Hyperactivity ♦ Loss of developmental skills (incontinence, self-care) ♦ Sleep disturbances
School Age	<ul style="list-style-type: none"> ♦ Depression, sadness, worrying ♦ Guilt, shame ♦ Feels responsible and helpless ♦ Anxious, hypersensitive to danger cues ♦ Distrust of adults 	<ul style="list-style-type: none"> ♦ Concentration and memory deficits ♦ Intrusive thoughts and images of violence ♦ Attempts to understand violence ♦ Ambivalence about family separation 	<ul style="list-style-type: none"> ♦ Declining school performance ♦ Inhibited, passive social behavior ♦ Aggression, destructive of property ♦ Defiance, disobedience ♦ Poor peer relationships
Adolescence	<ul style="list-style-type: none"> ♦ Self-blame, guilt, shame, suicidal ideation ♦ Anger, rage, explosive feelings ♦ Depression, hopelessness ♦ Lack of empathy for others ♦ Suspicion and distrust of adults 	<ul style="list-style-type: none"> ♦ Intrusive thoughts and images of violence ♦ Concentration and memory deficits ♦ Confusion of love with violence ♦ Belief that assault is normal ♦ Blame others for own behavior 	<ul style="list-style-type: none"> ♦ School failure ♦ Increased sexual activity ♦ Substance abuse ♦ Explosive and violent interpersonal behavior, delinquent behavior ♦ Violence & abuse in dating relationships

Adapted from the Wisconsin Department of Corrections, Domestic Violence: A Handbook for Agents

STRUCTURED DECISION-MAKING MODEL
Example of Risk Assessment Tool
 Wisconsin Urban Caucus
 Kenosha, Milwaukee, Racine and Waukesha Counties

FAMILY RISK ASSESSMENT OF FUTURE ABUSE/NEGLECT

4/98

Case Name: _____ Primary Caregiver: _____ Date: ____/____/____
 Case Number: _____ Secondary Caregiver: _____

Neglect	Score	Abuse	Score
N1. Was Neglect Alleged or Substantiated in the Current Investigation?		A1. Was Abuse Alleged or Substantiated in the Current Investigation?	
a. No	-1	a. No	0
b. Neglect alleged but not substantiated	1	b. Yes	1
c. Neglect substantiated	2		
N2. Prior Neglect History		A2. Prior CA/N History	
a. No prior substantiations of neglect	0	a. No CA/N history	-1
b. Prior substantiated incident of neglect	2	b. Any prior child welfare CA/N referral	1
		c. Prior substantiated abuse incident	2
N3. Caregiver(s) Viewed Current CA/N Incident at Least as Seriously as the Investigating Worker		A3. Does Caregiver(s) Use Excessive or Inappropriate Discipline?	
a. Yes - both caregivers	-1	a. No 0	
b. Yes - one caregiver	0	b. Yes - secondary caregiver only	1
c. No - neither caregiver	1	c. Yes - primary or both caregivers	2
N4. Current Age of Primary Caregiver		A4. Does the Primary Caregiver have a History of Abuse or Neglect as a Child?	
a. 33 or older	-1	a. No	0
b. 24 - 32	0	b. Yes	1
c. 23 or younger	2		
N5. A Child was Inadequately Supervised by Either Caregiver		A5. Primary Caregiver's Relationship Problems with Other Adults ...	
a. No	0	a. No serious problems evident	-1
b. Yes	1	b. Harmful relationships/limited adult relationships	1
N6. Primary Caregiver has an Alcohol or Drug Abuse Problem that Contributed to the Incident		A6. History of Domestic Violence in Household	
a. No	0	a. No	0
b. Yes	1	b. Yes	2
N7. Primary Caregiver Motivated to Improve Parenting Skills		A7. Caregiver(s) is Motivated to Improve Parenting Skills	
a. Yes	0	a. One or both caregivers are motivated	0
b. No	1	b. Neither caregiver is motivated	1
N8. Number of Children Involved in the CA/N Incident		A8. Age of Youngest Child in Household	
a. One or two	0	a. 12 or older	-1
b. Three or more	2	b. 11 or younger	0
N9. Age of Youngest Child in Household			
a. Six or older	-2		
b. Five or younger	1		
TOTAL NEGLECT RISK SCORE	_____	TOTAL ABUSE RISK SCORE	_____

RISK LEVEL

Assign the family's risk level on the highest score on either scale, using the following chart:

Neglect Score	Abuse Score	Risk Level
_____ -5 to -2	_____ -3 to -1	_____ Low
_____ -1 to 1	_____ 0 to 2	_____ Medium
_____ 2 to 4	_____ 3 to 6	_____ High
_____ 5 to 13	_____ 7 to 10	_____ Very High

STRUCTURED DECISION-MAKING MODEL
Example of Service Level Standards
Wisconsin Urban Caucus
Kenosha, Milwaukee, Racine and Waukesha Counties

Family Service Level	Service Standard
Low	1 Face-to-Face Contact/Month + 1 Collateral Contact/Month
Moderate	2 Face-to-Face Contacts/Month + 2 Collateral Contacts/Month
High	3 Face-to-Face Contacts/Month + 3 Collateral Contacts/Month
Intensive	4 Face-to-Face Contacts/Month + 4 Collateral Contacts/Month

For children in placement, the following child service standards are in addition to the family service standards. The standard applies to each child in placement.

Child Service Level	Service Standard
Level 1	1 Collateral Contact/Month
Level 2	1 Face-to-Face Contact Every Third Month with the Child + 1 Collateral Contact Every Third Month
Level 3	1 Face-to-Face Contact/Month with the Child in Foster Home + 1 Collateral Contact/Month
Level 4	2 Face-to-Face Contacts/Month with the Child in Foster Home + 2 Collateral Contacts/Month

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Cost Projections for Implementation of Screening and Targeted Intensive Home Visiting

(excludes current level services for short-term home visiting provided by Public Health Department)

Option 1: Families with Infants and Children to Age 5 Years

	Year 1	Year 2	Year 3	Year 4	Year 5 and Ongoing
Fiscal Resources for Full Implementation	\$2,003,750	\$2,964,125	\$3,285,000	\$3,479,125	\$3,673,250
Staff Resources Needed	2.0 FTE PHNs 30.0 FTE Home Visitors 3.75 FTE Supervisors	2.0 FTE PHNs 45 FTE Home Visitors 5.875 FTE Supervisors	2.0 FTE PHNs 50.0 FTE Home Visitors 6.5 FTE Supervisors	2.0 FTE PHNs 53.0 FTE Home Visitors 6.875 FTE Supervisors	2.0 FTE PHNs 56.0 FTE Home Visitors 7.25 FTE Supervisors
Total # Families Served					
• Universal Screening	• 5,000 families	• 5,000 families	• 5,000 families	5,000 families	5,000 families
• Intensive Home Visiting	• 600 families	• 1,200 families	• 1,600 families	2,000 families	2,400 families

Option 2: Families with Infants and Children to Age 3 Years

	Year 1	Year 2	Year 3 and Ongoing
Fiscal Resources for Full Implementation	\$2,003,750	\$2,964,125	\$3,285,000
Staff Resources Needed	2.0 FTE PHNs 30.0 FTE Home Visitors 3.75 FTE Supervisors	2.0 FTE PHNs 45 FTE Home Visitors 5.875 FTE Supervisors	2.0 FTE PHNs 50.0 FTE Home Visitors 6.5 FTE Supervisors
Total # Families Served			
• Universal Screening	• 5,000 families	• 5,000 families	• 5,000 families
• Intensive Home Visiting	• 600 families	• 1,200 families	• 1,600 families

Option 3: Infants and Children to Age 3 Years Born to First Time Single Mothers, Who Are Teens and/Or at Poverty Level

	Year 1	Year 2	Year 3 and Ongoing
Fiscal Resources for Full Implementation	\$1,641,250	\$2,233,047	\$2,470,375
Staff Resources Needed	1.0 FTE PHNs 25.0 FTE Home Visitors 3.25 FTE Supervisors	1.0 FTE PHNs 34.375 FTE Home Visitors 4.42 FTE Supervisors	1.0 FTE PHNs 38.125 FTE Home Visitors 4.9 FTE Supervisors
Total # Families Served			
• Universal Screening	• 2,030 families	• 2,030 families	• 2,030 families
• Intensive Home Visiting	• 500 families	• 800 families	• 1,000 families